NHS Highland
Care Home Collaborative Support Plans
(V0.6 - FINAL)

Care Home Collaborative Preamble

We welcome the Scottish Government letters of 14 December 2022 and 17 March 2023 and their focus on wider collaboration around care homes.

Our submission covers the funding allocated to NHS Highland arising from these communications, this being **£864,800 for 2023-2024,** which is understood to be non-recurring.

Using the apportionment previously applied to the original funding (and based on bed numbers), this represents funding of **£681,895** for Highland region and **£182,905** for Argyll and Bute.

This template sets out high level information relating to the overall approach of NHS Highland to the application and implementation of this investment, and is complemented by individual and more detailed appendices for North Highland and Argyll and Bute. It is noted that there are distinct service differences so whilst the principles are the same, there will be contextual descriptors to each response.

Although this investment is very much welcomed, it is highlighted that there are arising issues associated with this funding, as follows:

- Care homes in the whole of Highland are significantly affected by a fragile remote, rural and island context. There are smaller care homes across these areas compared to elsewhere, and these care homes are more widely spread and have higher costs. The change in funding from an NRAC share to care home bed numbers advantages those geographies with larger care homes and beds and disadvantages Argyll and Bute in particular, with 4 small care homes on three islands. We note that Island Health Boards attract additional funding, yet Argyll and Bute with a largest number of inhabited islands of any health board area, do not. This loss on funding for Argyll and Bute has impacted on our bid.

- Whilst we appreciate this was the original formula utilised during the pandemic, this was done in an emergency situation and we now believe more consideration is required in relation to how we ensure equity of support for this vulnerable care sector based on area profile rather than bed numbers. The calculation of funding is outwith the usual NRAC formula that is used for all other allocations which is aimed at ensuring equity of allocations across Scotland.

- These concerns were highlighted in a meeting held at the request of NHS Highland which was attended by SG colleagues and Louise Bussell, Nurse Director and David Gibson, CSWO, Argyll and Bute. A letter has been compiled and sent as a follow up to this conversation highlighting the concerns referenced here and we hope to have further dialogue about this in the near future.

- The non-recurring nature of the funding impacts on our ability to recruit into attractive roles quickly particularly where we have adapted to develop new roles to meet the spirit of the guidance.

1. What are the overall aims and anticipated outcomes of the work of the CCHS team, taking account of learning to date?

To ensure the optimum level of support as locally as possible and given our geography, we plan to have Collaborative Care Home Support Teams (CCHSTs) in Argyll and Bute and Highland region. The two teams will work closely together to ensure consistency of approach, cross Board area collaboration and to share learning and development.

The CCHSTs will work to a delivery plan agreed with care home sector representatives.

The CCHSTs will focus on embedding My Life, My Care, My Home, the Health Care Framework, including fundamentally, the recognition that care homes are residents' homes.

The CCHSTs will support the implementation of Excellence in Care in all care homes and will work closely with care home providers, managers and local health and social care services to support safe, high quality, compassionate care.

The CCHSTs will recognise and ensure that the voice of lived experience and support for families of those living in care homes, is paramount and can be demonstrated.

Outcomes will be developed as part of this work.

2 i). Outline how the CCSH team will support the objectives outlined in the 14 December 2022 letter?

The two CCHSTs will be expanded multi professional teams, available on a collaborative approach to enable care home colleagues to adopt a pro-active approach.

The CCHSTs will deliver both proactive and reactive services driven by requirements identified by the Care Home Manager / provider / sector and will support the delivery of education, quality improvement programmes and embed changes to practice through role modelling and mentorship, and adopting a facilitator approach, to promote continued learning and self-management.

There will be a collaborative approach to the leadership of the CCSHs.

Both areas have strong networks with providers and these networks will be essential to our collaboration.

2 ii). How will the funding will be used to contribute to overall improvement and building capacity for improvement? (it might be helpful to use the pillars outlined in the healthcare framework to structure answer)

Nurturing Environment – Continued recognition of the knowledge and skill set of existing social care teams, provision of robust enhanced induction and training to ensure teams are confident and competent in the delivery of safe and effective care. Collaborative working with care staff teams will ensure they are involved in the development of roles within current job description parameters. Expanded provision of access to Nurse, Social Work and Allied Health Professionals with specialist knowledge and experience in Adult Social Care.

The Multi -Disciplinary Team – The CCHST will provide increased ease of rapid access to multi-disciplinary team specifically for Care Home residents to ensure timely intervention.

Prevention – The CCHST, through demonstration and education, will support care homes to embed a positive outcomes informed approach.

Anticipatory Care, Self -Management and Early Intervention – Nursing resource to support Care Home Teams and primary care to ensure consistent and proactive approach to Anticipatory Care planning. Continued and expanded work to embed realistic medicine principles in care homes. Supporting care home teams to be key participants in Anticipatory Care Planning for residents, utilising their unique relationships with resident and families, ensuring consideration of physical and mental health care needs.

Urgent and Emergency Care – Increasing access for care homes to relevant members of the MDT in response to urgent and unscheduled needs of residents with a view to supporting individuals to remain within their home wherever possible. Continue to embed principles of realistic medicine in response to urgent and emergency situations within care homes.

Palliative and End of Life Care – Resource will be able to support delivery of training and education.

A Sustainable and Skilled Workforce – The CCHST will provide an opportunity to facilitate interdisciplinary multi-sector learning to build upon the existing skills to support individuals living in care homes. The CCHST will support meaningful and consistent education and training that is fit for purpose and which recognises the increasing complexities of their roles. Professionals within the CCHST will be able to provide ongoing support to invest in the development of care home managers through mentorship. There will be capacity to provide clinical and professional leadership to registered nurses working within care homes.

Data, Digital and Technology – Support care home teams in the use of technology to support remote health care delivery for Care Home residents. Use of Near Me to reduce avoidable travel if this is the individuals wish. Promotion of Telehealth resources for individuals living in care homes.

3. How are the CCHS team monitoring and evaluating improvement? If easier please send standalone reports have been carried out on specific projects to date.

- 2022/23 evaluation of educational provision to Care Homes, as well as CHLT input which was reviewed twice during the year to allow the team to adapt and develop to meet the needs of services and residents (North Highland specific). The use of Microsoft forms has been successful to gather feedback from care home teams and would continue to use this tool to monitor and evaluate services and improvement.

- Argyll and Bute has provided individual reports through Clinical and Care Governance frameworks and the Integration Joint Board.

- Continued contractual monitoring and engagement at provider level via individual contract meetings

- Engagement and partnership working with Scottish Care Independent Sector Lead.

- Qualitative feedback from residents, families and professionals.

- Ongoing monitoring of Care Inspectorate reports and grades, as well as other reporting trends via TURAS / DATIX / Hospital Admission Data / Out Of Hours contacts.

- Ongoing oversight of care home RAG assessment

Going Forward:

- There is a need to understand the individual human experiences of those living in the care homes in our area, a picture perhaps beyond that painted by “hard data” and capturing the narrative expressed by those with lived experience to enrich the stories behind the numbers is key. This is in order to check in, and to ensure that the directed efforts and resource is making a positive and tangible impact to residents on the ground, and to be able to recognise this and alter course as required. Embedding a human rights approach around this is essential.

- Consolidate all current reporting and to ensure that resident outcomes and impact are appropriately and specifically recorded and monitored for intended direction / impact. This a key action area for the plan for 2023-2024.

4. How has the funded team contributed to the improvements?

- Enabled faster and direct access by care homes to timely and specialist input.

- Provision of hands on practical deployed resource when needed, sometimes at very short notice.

- Real time direct and responsive input and advice to support and improve individual residents’ wellbeing journey.

- High level of positive sector feedback of interactions, inputs and collaborative approaches.

5. What has worked well so far (what will you consider scaling up for example)?

North Highland

- **Care Home Liaison Team**
  The existing Care Home Liaison Team worked with specific caseload areas; this allowed the team to build positive collaborative relationships with Care Home Managers, staff and residents. The team were able to provide support on site in care homes to deliver education, support complex clinical care, facilitate Multi- Disciplinary meetings and reviews, in a way that was easily accessible in the current pressurised system. Continuation of a relationships based approach utilising appreciate enquiry will be key to future success of the expanded team.

- **Covid / Community Response Team**
  The early development of a covid response team during the pandemic has provided a good learning opportunity in relation to how a responsive team can be key in the prevention of escalation and promotion of quality experiences for residents and staff teams. We will use this learning along with that from Care Home Nursing Liaison Team (CHNLT) to inform the development of the CCHST.

- **Reservists**
  Following the height of the pandemic and the long term effects of Covid, it was recognised that we needed to think of creative ways to enhance the workforce. NHSH have developed a Reserves resource which targeted a particular group of people to recruit. The key to this successful drive was flexibility and co-production and this learning will also be applied in the development of the CCHST.

- **Care Home Risk Assessment Framework**
  A Care Home RAG has been developed and is currently being internally utilised for sector assurance oversight. The continued use and review of this tool is intended.

Argyll and Bute

- **Care Home Quality Assurance Framework**
  Has been developed for the internal care homes of Argyll and Bute.

- **Collaborative Approaches**
  Argyll and Bute Care Home Assurance Framework is inclusive of Scottish Care and the Care Inspectorate (as well as nursing, social work and operational leadership). The meetings and actions have been reported via Argyll and Bute Clinical and Care Governance arrangements and this has supported wider learning. Scottish Care facilitate a Care Home Managers meeting which feeds into the present assurance framework.

Across the whole of NHS Highland the support of dedicated health protection staff for training and management has been a positive benefit.

6. What has worked less well so far? What have your learned that would be valuable to share with others (including challenges that you have had to overcome?)

A collaborative approach and maintaining relationships with the care home sector has been the most significant lesson in these challenging times.

Market fragility has been really testing for all of Highland and the level of input, effort and technical skills to respond to each arising and unique situation has been significant.

A central source / point of built up expertise would be useful to call upon for future arising situations to support Partnership decision making where this involves potential closures / step ins / acquisitions. This is not to detract from localised decision making and governance.

Decisions around either closing care homes or taking over activity to ensure their continuation, has direct and significant impact on outcomes for those living in care homes.

7. Please detail anything else you would like to share with Scottish Ministers?

Care home market fragility in Highland has been significant, with 4 care home closures in last 12 months (plus a further care home closure imminently concluding) in north Highland and 1 in Argyll and Bute.

The closure of one nursing home in Argyll and Bute was only averted by the decision of Argyll and Bute Council and the Integration Joint Board to both purchase and operate Kintyre Care Centre with no additional funding resource. This took over a year's worth of work with the Provider.

This was similarly the case for north Highland, where the closure of Main's House, which was in administration, was avoided following the decision by The Highland Council and NHS Highland to acquire and operate, although no additional funding was available. This acquisition and transfer also took over 12 months to achieve.

This fragility is compounded by the Highland size and scale of operator and care home, and significantly disadvantaged by the NCHC which is predicated on a 50 bed care home operating at 100% occupancy. Only 5 of the 48 Independent Sector care homes in North Highland, and only 2 care homes in Argyll and Bute, are 50 beds or more.

It is anticipated that the absence of a) an agreed NCHC rate for 2023-2024 and b) arrangements which financially recognise smaller scale provision, will have further significant destabilising impacts.

The lack of an agreed NCHC for 2023-2024 presents a significant care home delivery risk across the country and in Highland in particular. Ministerial support to assist to reach a national resolution with the sector, and one which recognises island, remote, rural and smaller scale delivery, is requested.

Study of the funding model is essential to take into account that Argyll and Bute in particular has a larger number of inhabited islands than any of the island health boards, yet does not attract the additional funding offered to island health boards. Funding founded on a calculation of numbers of care home beds is too simplistic for non urban settings and is to the disadvantage of those living in remote and island areas.

8. Please provide details of the expenditure of this funding, broken down into resource e.g. staff, whether full or part time, £value (see table below)

Highland Health and Social Care Partnership				
Allocation				*£681,895*
Resource	**Hours**	**Band**	**FTE**	**Total Cost**
Collaborative Care Home Support Team				
Senior Care Home Nurse		7	2	£132,232
OT		6	1	£55,272
SLT		6	0.5	£27,636
Physiotherapy		7	1	£66,116
HPT Nurse (north Highland share)		7	1	
HPT Nurse (north Highland share)		6	1	£97,545
Administrative Support		4	1	£34,409
Travel and other recurring non-pay				£15,000
Non-recurring IT				£10,000
Training				£24,000
Maximising resident experience				£55,179
Sub Total				**£517,389**
Collaborative Workforce Solutions				**£120,000**
Collaborative Sector Support				
Bed availability support and release		5	1	**£44,470**
TOTAL				**£681,859**

Argyll and Bute Health and Social Care Partnership				
Allocation				*£182,905*
Resource	**Hours**	**Unit Cost**	**FTE**	**Total Cost**
Social Care Lead Care Homes		LG13		£63,000
Associate Lead Nurse				£82,000
HPT (A&B share)				£23,843
Admin Coordinator			PT	£18,000
TOTAL				**£186,843**

Comments: AB HSCP would need to find/add £3,938 **£3,938**

Appendices

Appendix 1 – Highland Health and Social Care Partnership (V0.9a)

Microsoft Word 97 - 2003 Document

Appendix 2 – Argyll and Bute Health and Social Care Partnership (V0.3)

2023-05-12-Appendix 2 - Argyll and Bute \

North Highland HSCP
Collaborative Care Home Support – 2023-2024 Funding Proposal Summary
Simon Steer, Director of Adult Social Care
V0.9a

Introduction

Whilst this paper focuses on new developments, it does not exist outwith a context of prior investment decisions and improvements. As such, the collaborative design has focussed investment on increasing practical AHP and nursing and social care support. This reflects prior investment in an enhanced Social Work and Social Care leadership structure and investment in Scottish Care independent sector lead posts.

The alignment of performance against outcomes will be defined through a detailed delivery plan. This may result in shifts in investment where evidence suggests alignment with attaining improved outcomes (eg safety and experience) could be improved by varied focus of investment.

To ensure cohesion of new developments with existing inputs, there will be a collaborative leadership approach, which takes account of the essence and intention of the Scottish Government's requirements as set out in its communications of 14 December 2022 and 17 March 2023.

Background - Care Homes

There are 65 care homes across north Highland, 48 of which (April 2023) are operated by independent sector care home providers and 17 of which are in house care homes operated by NHSH.

Internal services are directly managed by operational district management, and the activity of independent sector care homes is monitored through a collaborative operational and commissioning approach, via an identified designated manager. Visibility of all care home activity and sector oversight is via the Commissioning Team, and operational supports are provided via district input, professional leadership from the Head of Registered services, professional input from the Care Home Nursing Liaison Team, Health Protection Team input and pulling on additional practical inputs (CRT / Reservists) as required and available.

Since April 2020, there has been a Clinical and Care Oversight Group, which has operated at varying frequencies as influenced by circumstances at the time. Currently there is a weekly review of operational sector activity, which assists to direct required input, in addition to ongoing responsive arrangements.

There has also been sector engagement throughout the pandemic, again, at frequencies responsive to prevailing circumstances. Presently, there is a 4 weekly Care Home Sector Business Stream meeting, which consists of a cross section of Highland care home provision (large, small, remote, rural and urban operators) along with the Scottish Care Independent Sector Lead (funded by NHSH). This is a helpful and effective forum for raising and understanding current issues and pressures. Further, there is now Scottish Care – Care Home representation on both the Strategic Planning Group and also the Joint Monitoring Committee, who are present to represent the voice of the independent sector.

Whilst there are various forums and opportunities in place to interact and engage with providers on an individual and sector level, there is absolutely a need to ensure activities are focussed on making a positive impact to the outcomes of those living in care homes and that there are mechanisms in place to be able to monitor that this intended impact is being achieved.

With the various mechanisms already in place, this additional investment provides a strong foundation from which to build an enhanced ability to promote and deliver improved outcomes, and from which to assess ongoing positive impact.

Requirements and Principles

This proposal and funding directly relates to the letter from Scottish Government of 17 March 2023 (and update of 24 March 2023) and the request within this communication for Partnerships to submit a plan for collaborative care home support arrangements for 2023-2024, in line with the allocated funding, for which **£681,895** is identified for north Highland Health and Social Care Partnership for 2023-2024.

The key focus of the intended areas of activity is on embedding My Life, My Care, My Home, the Health Care Framework and for tangible actions for improving outcomes for adults living in care homes.

This is not just a plan for spend but a plan for a change of approach to support care homes across sectors to have structured NHSH organisational support when requested and to recognise that services are best delivered, and service outcomes for residents are optimised, where organisations work together as equal partners and with mutual respect.

The development of the plan has involved input from and collaboration with, Scottish Care representation. This input is fundamental, given that the organisations who deliver services to care home residents, have the best overview of what is required to achieve improved experiences and are best placed to improve outcomes for those to whom care is delivered.

The key priorities of Scottish Care partners in delivering improved outcomes to those supported by them, are around responsive pull down support, specific care home manager support, collaborative workforce solutions and collaborative sector support.

These areas comprise the core activity areas of this plan and the HSCP, in collaboration with Scottish Care, have therefore identified actions which will enable this funding to be used to create conditions which allow capacity for improvement in line with the core elements of the Health Care Framework "My Health, My Care, My Home". Our proposal will support improvement across the core elements, however a focus lies within the following key areas;

- Nurturing environment
- Multi disciplinary team,
- Anticipatory care, self management and early intervention; and
- Sustainable and skilled workforce.

Overarching Aims

The Collaborative Support Care Home Team (CCHST) will work to a delivery plan agreed with care home sector representatives in north Highland.

The CCHST will focus on embedding My Life, My Care, My Home, the Health Care Framework, including fundamentally, the recognition that care homes are residents homes.

The Care Home Collaborative Team will recognise and ensure that the voice of lived experience and support for families of those living in care homes, is paramount and can be demonstrated, and will work to create a dynamic environment where the skills of care staff are recognised and maximised.

The Proposal

Collaborative Care Home Support Team

- Responsive, accessible, practical and senior support: through the creation of an expanded multi professional CCHST available on a “pull down“ basis to enable care home colleagues to adopt a pro active improvement approach.

- Collaborative leadership and management arrangements will foster a holistic care approach to the CCHST’s operation and delivery and to appropriately supporting residents in their home.

- The CCHST will comprise nursing, physio, OT, HPT and dietetic input, and will deliver both proactive and reactive services driven by requirements identified by the Care Home Manager / provider / sector.

- The CCHST will support the delivery of education, quality improvement programmes and embedding changes to practice through role modelling and mentorship, adopting a facilitator approach, to promote continued learning and self management.

- Nursing input within the CCHST, as well as promoting quality, education, and providing role modelling, mentoring and support to care home managers, supporting staff, and nurses within the care homes, will also support with revalidation with the NMC professional body.

- HPT input and activity will be part of a coordinated MDT approach.

- The CCHST will deliver specialist and timely input and advice specific to individual residents, as well as the education and facilitation role.

- Sector feedback is that Managers are feeling under ongoing and sustained pressure and need additional but tangible support and that some of this pressure is attributable to a loss of confidence of staff working within the care home arising from their pandemic experience. Key to alleviating some of this pressure is to support, encourage and promote staff confidence and competence to work to the top of their licence. The embedded educator, facilitator and nurturing approach of the CCHST will support this intention.

- The requirements of the health and social care standards, local and national policies will also influence the development of the CCHST, its composition and, suite of available resources such as themed training around identified need areas, eg arising from Care Inspectorate inspection outcomes, issues flagged by Business Stream, Datixs,

- Supporting maintained family / friend relationships is key to promoting resident wellbeing. The Partnership's Carers Lead will also link into the CCHST to support positive mechanisms for information and advice to families and carers of those living in care homes. This will also be an activity area within the delivery plan for the Business Stream to seek to establish, promote and embed effective mechanisms for contact and engagement with families.

- Both hard and soft data will be utilised in evidencing a positive impact on those living in care homes, their families and also staff working within these homes.

    - We will seek to establish data via an enhanced audit mechanism in relation to falls, food fluid and nutrition, skin integrity, meaningful activity, stress and distress and medication. By using a relationship based approach and person directed support planning based on outcomes, we will gain ongoing feedback from people who use services, their families and the workforce. This will be achieved by regular check in's informally, formal reviews, family / friends involvement and feedback from staff teams.

    - We will also monitor impact on acute services in terms of preventing unnecessary admissions to hospitals or a requirement to "move on" to Nursing settings. By maximising the skillset of current care staff we will also be able to record how this has impacted on requests for specialist input and current delays in accessing this input.

- NHSH will work with Scottish Care to undertake a joint evaluation across both sectors and checkpoint arrangements will be put in place to review and adjust course as required.

- **Impact for Residents:**

    - Residents get individual MDT specialist support when they need it – an early intervention and prevention focus will improve resident outcomes.
    - Residents and their representatives are fully involved in the process which can be adapted to reflect needs and wishes.
    - Residents benefit from care home staff's embedded learning and increased confidence.
    - Staff decision making nearer to the resident, enabling empowerment and meaningful involvement, and improved retention.

- **Alignment with Healthcare Framework core element(s):**

    - Nurturing environment
    - Multi disciplinary team,
    - Anticipatory care, self management and early intervention; and
    - Sustainable and skilled workforce.

- **Action:** the **Collaborative Care Home Support Team delivery plan** to be discussed, agreed, monitored and evaluated through the Care Home Business Stream meeting.

Collaborative Workforce Solutions

- Conduct baseline workforce assessment: to fully understand the reasons why a potentially available workforce are not choosing to work within a social care environment. This needs to inform how this gap is to be addressed.

- Review of workforce deployment: to fully understand the collective utilisation and deployment of both care and nursing resource, to ensure the resource that is available is being collectively and holistically deployed to best use.

- Combined workforce delivery plan: to tackle recruitment and retention across sectors together, simplify recruitment and training, use more creative approaches to recruitment and address the competition between sectors for the same staff, along with agency reliance.

- **Impact for Residents:**

    - Residents benefit from staffing levels being met and improved staff continuity, enabling residents and their families to build relationships and trust with those delivering care.

- **Alignment with Healthcare Framework core element:**

    - Sustainable and skilled workforce.

- **Action:** the **collaborative workforce delivery plan** to be discussed and agreed through the Care Home Business Stream meeting.

Collaborative Sector Support

- Bed availability support and release: improve real time availability, bed capacity understanding and processes to enable responsive support to release unavailable beds.

- The HSCP contracts with Scottish Care to provide direct support to Managers and to lead on items with care homes and the HSCP (already funded).

- Co-produce mechanisms for oversight of sector sustainability (funding not requested).

- Joint contingency planning for care home failure (funding not requested).

- **Impact for Residents:**

    - Residents, currently in inappropriate settings, are able to access care home placements.
    - Improved quality of experience when transferring to a care home.

- **Alignment with Healthcare Framework core element(s):**

    - Not specifically aligned to any individual core element, but the intention around this activity area is to free up bed capacity, expedite placements to care homes, and improve peoples' experiences when transferring to a care home, thereby achieving an improved outcome for those particular individuals currently in inappropriate settings.

- **Action:** the **collaborative sector support delivery plan** to be discussed and agreed through the Care Home Business Stream meeting.

Costings

As per **Appendix 1** attached:

Reporting and Governance

It is proposed that:

1. A Collaborative Care Home Support Team is established as above, which builds upon current support arrangements already in place and which is embedded and managed within the Adult Social Care leadership structure, providing for a holistic care approach.

2. The weekly operational care home meeting is repurposed to support the CCHST.

3. The Care Home Business Stream meeting will remain meeting 4 weekly and will have a role in overseeing delivery plans.

4. A Clinical and Care Governance Group is established for Care Homes and Care at Home.

5. A Collaborative Care Home Strategic Group is established within north Highland, comprising operational and strategic representation across the breadth of areas reflecting our current care home context. This replaces the north Highland representation at the NHS Highland Oversight Group.

6. The delivery plans described above will be overseen by the Business Stream and progress and delivery will be reported to the Collaborative Care Home Strategic Group.

Appendix 1

Collaborative Care Home Support Team
Funding Proposal to SG for 2023-2024
Proposal V0.12 (11 May 2023)

North Highland Allocation £681,859

Collaborative Care Home Support Team	Band	WTE	Cost	Comment
Head of Registered Services, ASC	8B	1		Already in place / funded from recurring ASC funding.
Lead Nurse	8A	1		Not yet in place. Funded from recurring ASC funding.
Principal Officer (Care Homes), ASC	8A	PT		Already in place / funded from recurring ASC funding.
Learning and Development Manager Support (Care Homes), ASC	7	PT		Already in place / funded from recurring ASC funding.
Project Manager	7	PT		Already in place / funded from recurring ASC funding.
Podiatry	7	PT		Already in place / funded.
Dietetic support	7	PT		Already in place / funded.
Senior Care Home Nurse	7	2	£132,232	
OT	6	1	£55,272	
SLT	6	0.5	£27,636	
Physiotherapy	7	1	£66,116	
HPT Nurse (north Highland share)	7	1	£97,545	
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Training			£24,000	
Maximising resident experience			£55,179	
Sub Total			**£517,389**	

Collaborative Workforce Solutions			**£120,000**	Plan to be developed with Scottish Care

Collaborative Sector Support	Band	WTE	Cost	Comment
Bed availability support and release	5	1	£44,470	

TOTAL			**£681,859**	